Health Benefits Exchange Board
Meeting Minutes
December 20, 2011

Attendees: Chair Meg Curran, Vice-Chair Don Nokes, Pamela Martinez, Health Insurance Commissioner Chris Koller, Linda Katz, Mike Gerhardt, Marta Martinez, Tim Melia, Dwight McMillan, Director of Administration Richard Licht, Director of Health Michael Fine

Absent: Secretary Steve Costantino, Peter Lee

I. Call to Order – Chairwoman Curran called the meeting to order at 1:00pm, and asked for introductions around the table. After introductions she turned the meeting over to Jennifer Wood, Office of the Lt. Governor, to begin a continued discussion of the basic health plan.

II. Basic Health Plan – Presentation by Jennifer Wood (available *http://www.healthcare.ri.gov/documents/Discussion%20of%20BHP%20Exchange%20Board%2012%2020%202011.pdf*:)

a. This presentation was designed to revisit the conversation started at the November 29 Board meeting.

b. Discussion & Questions during Presentation:

i. One other risk that is noted here is that it requires legislation. This may be a risk as unrelated and irrelevant issues can arise in the legislative process. Ms. Wood concurred.

ii. Is there any factor for the collectability of these premiums, and the cost of collecting premiums? Ms. Wood replied that she believes they have an administrative load similar to the current RIte Care program. If one does not pay a premium, one does not get insurance for some time.

1. As a follow up it was pointed out that to catch up with that, there will be provisions down the road to protect from total shut-off.

iii. Looking at bad debt, terms of bad debt can be replicated in the RIte Care policies – cannot keep just the RIte Care amount, as will be dealing with a larger group. Ms. Linda Katz responded that under RIte Care if don't pay for two months, off for four months – not a great system. Whether that is something that would be carried on with BHP is an interesting question to consider.

iv. RIte Share is a big issue as well. Any new information from the federal government on a RIte Share like program? Ms. Wood responded that there is no new information at this time.

v. On the reinsurance, is it a stop-loss for total losses in the plan, or is it a stop-loss on an individual level? The response was

that it is on the individual, not on the overall. Taking individual claims within a certain range; one risk-containment tool, not the entire toolbox.

1. The question followed, doesn't it raise the cost and diminish affordability? To this, Ms. Wood responded that the reinsurance comes from a provider fee as applied broadly across the entire market, it is a win to the individual market, a cost to the other aspects of the marketplace – net gain. This is a federally imposed fee.

vi. Q. Is there to be no change in RI statute to fund the reinsurance? A. If the BHP is in the exchange, then in the individual market and subject to the advantages of the reinsurance. We do not know if Rhode Island opts for the BHP that the federal government will allow that population to still be eligible under the federal rule. If the federal government does not allow this, what this mitigation strategy addresses, is that we could address it legislatively at the state level to include the BHP population.

1. Q. Would you then be required to have a state reinsurance premium? Commissioner Koller noted if the feds didn't allow it, and RI did proceed, then would need to administer our own.

vii. Q. Are there numbers on the eligibles? A. Kids below 250% FPL and parents below 133%FPL. However, when look at those funds that are currently invested, there is a potential source to go around funding the uncertainty of the program. Ms. Katz interjected to point out that 9,000 parents between 133% and 175% FPL who will no longer be eligible, it is a significant number of individuals who may find themselves looking for insurance.

viii. The observation was made that whether they are in the basic health plan, or in the exchange, those 9K will be facing a higher premium than they are currently paying, but the state will be saving $15million which could be used to hold them harmless.

ix. The question then arises whether this would be merely shifting the cost from the government to the individual? Is that the goal of this, or is the goal to keep people insured and have more individuals insured?

x. One thing to consider – do we continue the RIte Care Premium. That would be a cost to the state, but speaks to the earlier question about what the goal is? Particularly with this population, a policy shift up or down may be very sensitive to our goal of achieving near universal coverage.

xi. *Q.* Can we, and if we can, should we, try to impact the federal decision? Is there an optimal answer to each of these questions that we should weigh in on? *A*. Emphatically yes.

Particularly, as RI is in the first cohort of states moving forward in this process that does give RI a bit more of the ear of the federal government.

1. *Q*. Don't we also want the reinsurance issues added to our slide of issues that need further development? *A*. Yes. The challenge with all this is that these questions are unlikely to be answered within this legislative session – timing makes this difficult. Commissioner Koller underscored Dr. Fine's point that we do want to include reinsurance on the issues that require further development and bring the question forward to the federal government.

xii. Note that other states have been asking RI for data as they're developing.

xiii. *Q*. The discussion at this point about adoption of the BHP has focused on a particular segment of the population, what effect the determination to adopt or not adopt the BHP has on other goals that have been articulated for the ACA and reform implementation? Going beyond this particular population, what other items should be considered in this decision? *A*. One example, very early on when BHP came up was one of the key concerns discussed -- if divert a portion of the population that would otherwise purchase coverage through the exchange, would that somehow make it so small that it would fail as a financially sustainable model for an exchange in RI? The population that is 200-400%FPL absolutely needs an exchange to access the subsidy, and 400% FPL and above are looking for a new marketplace to be able to fulfill their obligations under the individual mandate.

1. The comment came to work on not letting a smaller program outrun the exchange. Belief is that as you look at both the small numbers challenge in RI and the emerging model for an exchange -- view it as a partner with other programs and offers a suite of programs throughout its case to the community, that its scale as receded, that not just a click through and purchase.

xiv. Q: In terms of the future of Medicaid, one of the concerns is that yes, ACA expands Medicaid, but it may eventually hurt the state – does the creation of a BHP help or hurt the state a few years out when the federal funding is gone? A. It was noted that the answer is unknown at this point, but it is a point to raise; the overall impact of RI implementation of health reform, and how Medicaid is affected. Use Medicaid as an actual safety net, but the decisions that we make are about a new marketplace, an exchange. Development of a BHP can be

viewed as potentially an expansive role for Medicaid not more limited.

1. Depends all on how much gets included in the benefit design of the BHP. The benefit design will be similar in the way that cost sharing is used, but the main difference is that it supports the Medicaid branch.
2. All of the additional services that Medicaid includes are aimed at meeting the needs of people eligible for Medicaid. The question that the ACA brings is whether states really want to start looking at Medicaid as the most needy, or as a broad response to low-income persons.

III. Discussion, Comments and Concerns by the Board on the Presentation

a. It appears that by preserving the ability for the state to pursue this, action may need to be taken in the spring of 2012.
b. Assume for the moment that with the BHP, it is breaking even, therefore there is a potential financial risk to the state. What would it cost the state to offer the same premium in the BHP… if the state is saving 15million, what would it cost to give that difference to the single adults -- To subsidize the subsidy? Is the $15 million the state share? Ms. Wood replied that it would not necessarily addresses itself to the programmatic aspects, it would address churn. Director Licht noted he would like to see that looked at, see if they could get clarification on that.
c. Data on affordability, some are uninsured now, and they may be against the wall in terms of cost already, we need to know the affordability of the take up population. What will people view as affordable? 5% of income sounds affordable to some, but may not be for all. There's a need to refine the analysis of the premium numbers for different income levels.
d. Population that would lose in access to affordable coverage if directed to access subsidies on the exchange, would lose the immigrant population (legal permanent residents). Not eligible for Medicaid, but cannot go through the exchange. The BHP may cover them – State Medicaid Director Elena Nicolella noted that is a concern for all options.
e. The take up rate in general is about 43% so the new survey in RI will provide more precise estimate at a new take-up rate for RI.
f. Need to look at the 400% FPL population as well, and what is concerned at that level for affordability. Data requested by income and coverage level. Some folks coming from uninsured and estimate how many in employer based coverage for whom that is unaffordable. What will happen to incomes, what will happen to employer-based coverage, what actions will we take in outreach to convey this? It is

not just a question for an economist on likely take up, but also actions we have to do.

g. The plan design of the basic health plan, out of pocket copays, impact on affordability, and also know the fees and alternatives Big piece of the folks coming into a BHP are those coming from employer-based coverage.
h. As the matrix is being developed, hope to include Medicaid. It was noted that we do have a model to build on.
i. Deciding as a group, how important this particular piece is – one of the things to be concerned about is that it does affect 19 – 30K people. There is so much to get done, and there's concern about where state needs to be in 2014. It does need to be inclusive, but we need to have a sense of where it is going to go.
    i. Ms. Wood interjected that it does actually effect what will be done down the line, and BHP does influence what we do. As continue talk to the Chair, to the stakeholders in the workgroups and the staff that feed and prepare these presentations to the Board, there has definitely been a conviction that there is a need now to know what are the basic goals for all segments of the population in RI. There were many discussions about this over a year ago, when this was abstract, so now there is a commitment on the part of the staff, to revisit those fundamental points of health reform, and what the goals are for the exchange and how to meet those.
        1. We will be working on an agenda moving forward.
j. At this point, the Chair commented to clarify that the state would need to move forward with some type of open-ended legislation to keep the possibility of the BHP alive while we consider if we should adopt it? Is that correct? Ms. Wood replied: There has been enough discussion here to know we need more information, and we want there to be time to investigate the questions that have been raised. The purpose today was that we needed to ensure there was enough interest to put forth an enabling legislation for additional legislation.
    i. The administration does not have a request for legislation pending, but have been told that legislation is being prepared.
    ii. Also reiterated that there is a need to cover the studies that relate to churn in the future.

IV. Updates

a. Dan Meuse, Office of the Lt. Governor, gave an update on what has recently developed on the issue of essential health benefits from the federal government.
    i. What the federal government stated was a baseline list of ten items that must be included in a plan in order for it to be offered on the exchange. On Friday (12/16) the Federal HHS announced their intention for the regulatory process for states to define their own packages provided it met the ten items

outlined in the initial statutes. Benefit packages will all be very similar, but the states will have a choice; will need to be out by third quarter 2012.

1. Who will make the choice? The bulletin states the "state must select," yet its unclear what that selection process may be. To the issue of who decides, that is a key question that the guidance has not yet delineated.
2. What it doesn't do is remove all mandates – it is, however, a federal incremental approach, choose among those norms. Just received this information on Friday, have not thought through the process implications, but will report out to the Board.

V. Public Comment
   a. Richard Langseth addressed the Board, noting that he sensed a bit of cultural inclusiveness, and expressed a desire for more public inclusion in these sessions, through agenda distribution and place for public comment. Mr. Langseth noted that the public has a great role in what is happening in reform, and make sure to consider than as proceeding

VI. Motion to adopt the minutes from the last meeting was put forth and seconded and the minutes were adopted.

VII. Adjourn